[COMMITTEE PRINT]

JUNE 16, 1999

[As Approved by the Subcommittee on Employer-Employee Relations on June 16, 1999]

106TH CONGRESS
1ST SESSION

H. R. 2046

To amend title I of the Employee Retirement Income Security Act of 1974 to ensure access by participants and beneficiaries of group health plans to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

IN THE HOUSE OF REPRESENTATIVES

JUNE 8, 1999

Mr. FLETCHER introduced the following bill; which was referred to the Committee on Education and the Workforce

[Strike out all after the enacting clause and insert the part printed in italic]

[For text of introduced bill, see copy of bill as introduced on June 8, 1999]

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974 to ensure access by participants and beneficiaries of group health plans to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Ensuring Informed Health Consumers Act of 1999".

SEC. 2. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

"DISCLOSURE BY GROUP HEALTH PLANS

"SEC. 111. (a) DISCLOSURE REQUIREMENT.—

"(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

"(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan description, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

"(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

"(1) COVERED ITEMS AND SERVICES.—

"(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

"(i) types of items and services (including any special disease management program); and

"(ii) types of health care professionals providing such items and services.

"(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

"(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

"(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

"(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

"(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

"(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

"(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

"(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

"(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

"(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

"(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care

may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

"(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

"(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

"(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

"(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical

care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

"(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

"(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges; and

"(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

"(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503, including—

"(1) descriptions thereof relating specifically to—

"(A) coverage decisions;

"(B) internal review of coverage decisions; and

"(C) any external review of coverage decisions; and

"(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

"(e) INFORMATION ON PATIENT SATISFACTION AND OUTCOMES.—Any information required under subsection (a) shall include a description of measures of patient satisfaction and outcomes under a group health plan (or health insurance coverage offered in connection with such a plan), including information concerning the number of external reviews under section 503 that have been completed during the prior plan year and the number of such reviews in which a recommendation is made for modification or reversal of an internal review decision under the plan. The description of measures of patient outcomes shall be based on data collected by the plan to the extent that such data is available to the plan as a result of the type of coverage options the plan provides.

"(f) INFORMATION AVAILABLE ON REQUEST.—

"(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

"(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) may, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format—

"(i) the latest summary plan description, including the latest summary of material modifications, and

"(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

"(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making

such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

"(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

"(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

"(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

"(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of

providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

"(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

"(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

"(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon

receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

"(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

"(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

"(vii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

"(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS.—

"(i) QUALIFICATIONS, PRIVILEGES, AND METHOD OF COMPENSATION.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Sec-

retary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

"(ii) COST OF PROCEDURES.—Any health care professional who recommends an elective procedure or treatment while treating a participant or beneficiary under a group health plan that requires a participant or beneficiary to share in the cost of treatment shall inform such participant or beneficiary of each cost associated with the procedure or treatment and an estimate of the magnitude of such costs.".

"(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

"(g) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

"(h) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

"(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations;

"(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants);

"(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification; or

"(4) by any other reasonable means of timely informing plan participants.

"(i) DEFINITIONS.—For purposes of this section—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 733(a)(1).

"(2) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

"(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

"(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).".

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended by inserting before the period at the end the following: "; and, in the case of a group health plan (as defined in section 111(i)(1)), the information required to be included under section 111(a)".

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

"Sec. 111. Disclosure by group health plans.
"Sec. 112. Repeal and effective date.".

SEC. 4. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this Act shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this Act, against a group health plan or health insurance issuer with respect to a violation of a re-

quirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.